Professional Associates, P. O. Box 1238, Sanger, Texas 76266 Phone: 877-738-4391 Fax: 877-738-4395

Notice of Independent Review Decision

Date notice sent to all parties: 05/02/14

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Radial tunnel and cubital tunnel release of the right elbow

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:

Board Certified in Orthopedic Surgery
Fellowship Trained in Hand Surgery

REVIEW OUTCOME:

Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

X Upheld (Agree)

☐ Overturned (Disagree)

☐ Partially Overturned (Agree in part/Disagree in part)

Provide a description of the review outcome that clearly states whether medical necessity exists for each of the health care services in dispute.

Radial tunnel and cubital tunnel release of the right elbow - Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

PATIENT CLINICAL HISTORY [SUMMARY]:

examined the patient on xx/xx/xx. She stated she slipped the day before and caught herself by grabbing the back of nearby chair. She did not fall to the ground and grabbed the chair tightly to hold herself up. She was wearing soft wrist brace at the time, as her wrist was sore from a lot of work activities. She had a past surgical history for a hysterectomy and a right hand third digit extensor tendon repair one year prior. She had pain to the right wrist with flexion and extension. The pain extended up to the mid forearm, posterior aspect, when she tried to flex or extend the wrist or when she tried to open a water bottle. She had no numbness, redness, edema, or bruising. She denied any loss of strength. Range of motion of the right wrist was decreased in flexion and extension. Her hand grips were strong and equal. She had tenderness to the carpal area in the mid to lateral aspect on the posterior side. Tinel's was negative. Sensation was normal. The assessment was a wrist sprain. Etodolac and a wrist brace were prescribed. On 05/30/13, she had improvement in swelling and her symptoms. The assessment was a wrist sprain and x-rays were negative. Therapy and Biofreeze were prescribed. examined the patient on 06/07/13. She had been working regular duty and taking her medications without improvement. She had had physical therapy. She right wrist pain in the radial aspect. The assessment was a wrist contusion. Therapy, Biofreeze, and an MRI were recommended. An MRI of the right wrist on 06/13/13 showed mild tenosynovitis involving the extensor digitorum tendon sheaths corresponding with the area of concern with the adjacent dorsal skin marker. The finding extended for approximately 2 cm. in length from the radiocarpal to the carpometacarpal joint space. The underlying tendons themselves were normal. It was felt the findings were presumably related to the patient's provided history of prior trauma. Otherwise, it was a normal study, but it was noted the study was affected by patient motion. On 06/18/13, she informed Ms. she was improving, but still had minor right wrist pain and right pinky tended to go numb. She was using a splint and Celebrex. The MRI was reviewed. The assessment was right wrist tenosynovitis. Celebrex, therapy, and regular duties were continued. Due to persistent symptoms, on 06/25/13, referred her to a specialist. examined the patient on 07/11/13. She denied numbness and tingling and prior injury. Right wrist flexion was 23 degrees and extension was 57 degrees. Flexion was painful in the dorsal central wrist, but extension was not painful. She had a very positive finger extension test causing pain in the dorsal central wrist, where she was tender, which was mostly over the fourth extensor compartment. Finkelstein's was negative and she had full range of motion of all the fingers and thumb. The MRI was reviewed. The assessment was right wrist extensor tenosynovitis, primarily of the fourth dorsal compartment. It was felt there was some degree of dorsal wrist capsulitis syndrome, as well. An injection was recommended and Naprosyn were continued. She was placed on modified duty through 07/25/13. On 08/01/13, performed a steroid injection into the right fourth extensor compartment. She was advised to continue the splint and the patient noted repetitive work increased her symptoms. She was kept on modified duty with limited repetitive activities through 08/15/13. On 08/22/13, the patient informed the injection removed almost all of her pain and she was doing normal work with the use of the splint. The right wrist had full range of motion and there was slightly decreased sensation on the dorsal central wrist, but the remainder of

the hand and fingers were normal. She noted she did not need anymore Naprosyn and felt she was ready for full duty. On 09/12/13, it was noted her pain was returning, but not necessarily in the wrist, but primarily at the proximal radial forearm. She pointed directly at the radial tunnel. She had no tenosynovial swelling and she had full range of motion of the wrist. The majority of her pain was in the radial tunnel area and she had a very positive resisted wrist extension test, which caused pain at the radial tunnel, but not the lateral epicondyle. The radial tunnel was very tender. felt the patient was showing clear signs of radial tunnel syndrome and an injection was performed at that time. On 10/03/13, the patient stated the fourth dorsal compartment injection did not help at all and she felt made her worse. She remained tender in the radial tunnel and the pain radiated up and down the lateral arm. recommended radial tunnel release and placed her on modified duty through 10/17/13. hand surgeon, examined the patient on 10/04/13. She noted she had localized pain over the lateral epicondyle and elbow, as well as mild wrist pain. The MRI was reviewed. She had pain to palpation over the extensor mechanism of the right forearm and lateral epicondyle. She had a positive ECRB test and she appeared to be neurovascularly intact. The impressions were right arm pain status post fall, right arm lateral epicondylar and elbow pain, possible radial tunnel, and right mild wrist sprain, improving. felt the patient likely had lateral epicondylitis and recommended another injection to that area. He did not feel she was currently a surgical candidate. On 10/10/13, the patient informed she had been off of work for five days and was not having any pain in the lateral elbow. He felt a lateral epicondyle injection was not necessary because she did not really have any pain there and again recommended the radial tunnel release. On 11/07/13, provided a notice of non-authorization for the requested right radial tunnel release. An EMG/NCV study dated 12/27/13 revealed an injury to the right dorsal ulnar sensory nerve, with normal motor nerve function through the Guyon's canal. There was evidence of mild or early right median neuropathy at the wrist, consistent with carpal tunnel syndrome. No radial nerve injury was noted. On 01/09/14, the patient presented with right wrist pain and numbness. She had tenderness of the radial tunnel, but not the lateral epicondyle or medial epicondyle. She had slight tenderness of the cubital tunnel. Elbow range of motion was normal. Sensory examination was intact in the median nerve, but Tinel's and Phalen's were positive at the elbow. The EMG/NCV study was reviewed and the impressions were right radial and cubital tunnel syndrome and surgery was recommended. On 01/30/14, the patient was unchanged and again recommended surgery. On 02/11/14, provided an adverse determination for the requested right radial tunnel release and right cubital tunnel release. On 03/26/14, provided another adverse determination for the requested right radial and cubital tunnel release. On 04/03/14, reexamined the patient. She had right elbow pain and she had pain, numbness, and tingling. He symptoms had worsened. She had no swelling or effusion and finger and wrist extension testing caused pain at the radial tunnel. Tinel's and Phalen's were negative at the wrist, but Tinel's was positive at the elbow. She stated the small and ring fingers were numb at times. noted they would again request the right radial tunnel release and

right cubital tunnel release, as she had maximized non-operative treatment. She would be taken off of work.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS, AND CONCLUSIONS USED TO SUPPORT THE DECISION:
The ODG treatment guidelines require a positive examination on electrodiagnostic studies and impact on strength to the radial tunnel and the cubital tunnel. Immediately following the injury and through 09/12/13, there was no mention of any right elbow or radial or cubital tunnel complaints or symptoms. She was treating for a right wrist sprain. On 08/22/13, she noted the injection relieved almost all of her pain and she had full range of motion in the right wrist. She noted she no longer required Naprosyn and was ready to return to work. Then, when she returned on 09/12/13, pain in the radial tunnel was noted. The EMG/NCV study showed evidence of carpal tunnel syndrome, but there was no evidence of any injury to the radial nerve. This was a very late diagnosis and was not treated conservatively. I do not see any documentation of bracing for the cubital tunnel syndrome or any other conservative treatment done. I also see no evidence of therapy for the right elbow to include strengthening as recommended by the ODG. The ODG further stated that surgical decompression of the radial tunnel syndrome, which they state to be a relatively rare condition, is controversial because the results are not predictable. At this time, I do not believe that the treating physician has met the ODG requirements for the requested right radial tunnel and cubital tunnel release of the right elbow. Therefore, the previous adverse determinations should be upheld at this time.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

- ☐ **ACOEM- AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE**
- ☐ **AHCPR- AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES**
- ☐ **DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES**
- ☐ **EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN**

☐ **INTERQUAL CRITERIA**

X MEDICAL JUDGEMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

☐ **MERCY CENTER CONSENSUS CONFERENCE GUIDELINES**

☐ **MILLIMAN CARE GUIDELINES**

X ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES

☐ **PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR**

☐ **TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS**

☐ **TEXAS TACADA GUIDELINES**

☐ **TMF SCREENING CRITERIA MANUAL**

☐ **PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)**

☐ **OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)**